| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155291 | A. BUILDING _____ B. WING _____ | R-C 04/10/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE VALLEY MEADOWS | 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS | {F 000} | | |

This visit was for a Post Survey Revisit (P.S.R.) to the Investigation of Complaint IN00104419 completed on 3/07/2012.

This visit was in conjunction with the Investigation of Complaint IN00105648.

Complaint IN00104419-Corrected.

Survey dates: April 9, 10, 2012

Facility number: 000188
Provider number: 155291
AIM number: 100266310

Survey team:
Chuck Stevenson RN, TC

Census bed type:
SNF: 5
SNF/NF: 96
Total: 101

Census payor type:
Medicare: 15
Medicaid: 69
Other: 17
Total: 101

Sample: 3

Eagle Valley Meadows was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the P.S.R. to the Investigation of Complaint IN00104419.

Quality review completed on April 11, 2012 by

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **EAGLE VALLEY MEADOWS** | **3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | Continued From page 1<br>Bev Faulkner, R.N. | {F 000} | | |